Individual and Family Supports

Goal: To Increase member's, family/support person's and guardian's understanding of effect(s) of the condition on the member's life and improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health and quality of life. The following activities are examples of the services that may be included in providing Individual and Family Supports and should be documented thoroughly in the member's care record.

Scenario: Care Coordinator visits the member and the family member that lives with the member. The Care Coordinator facilitates a discussion about the member's Health Action Plan (HAP), and how the family member might be able to help the member be successful in meeting these goals. As an example, the members Health Action Plan goal may be to lower their low-density lipoprotein (LDL) cholesterol by avoiding fried foods. The family member may work at a restaurant and routinely brings home leftover fried foods. The discussion could focus on how to show love in another way, how avoiding bringing these foods home supports the member's goal, available educational opportunities that strengthen member self-care and family support, and whether there are alternative food choices that would be healthier options.

- Completion of screening tools or questionnaires with the member and family/support persons that help identify gaps in self-care knowledge, environmental risks, personal safety, management of finances, etc.
- Offering information to the member and family/support persons about community resources such as support groups, educational seminars, health fairs or other activities that are available online, via phone, or in person
- Ensuring member and family/support persons understanding of and appropriate use of all Medicaid benefits, waiver benefits, or other services

Care Coordination

Goal: Care coordination is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals. The following activities are examples of the services that may be included in providing Care Coordination and should be documented thoroughly in the member's care record.

Scenario: As part of the assessment and in consultation with the member's primary care physician (PCP) it was determined that the member should be seen by a dermatologist. The Care Coordinator will assist the member by researching dermatologists available in the Managed Care Organization (MCO's) network. The Care Coordinator will review the options with the member, and work with the member to schedule an appointment and transportation to the appointment for the member. The Care Coordinator may accompany the member to the appointment and assist in helping the member to understand the information presented. The Care Coordinator will follow up with the member after the appointment to confirm understanding and receipt of new medications or self- care management. The Care Coordinator will provide an update to the PCP or other providers about the new treatment as prescribed by the dermatologist.

- Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care
- Activities to achieve the goals listed on the member's HAP
- Monitoring Emergency Department (ED) and in-patient admissions
- Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects, referring for LTSS, locating non-Medicaid resources
- Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports
- Creates and promotes linkages to other agencies, services, and supports by referring, scheduling appointments, follow-up after appointments

Comprehensive Care Management

Goal: Coordination and collaboration with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, the development of a Health Action Plan (HAP) and subsequent revisions or updates to the HAP. The following activities are examples of the services that may be included in providing Comprehensive Care Management and should be documented thoroughly in the member's care record.

Scenario: The Health Home Partner (HHP) receives their panel listing from the MCO. This triggers the HHP to begin gathering information about the member in preparation for outreach attempts and the face to face visit. Check Kansas Medical Assistance Program (KMAP) for Medicaid eligibility and spend down status (if applicable).

- Review health care utilization data available via the MCO portal
    - Compare utilization of services to evidence based guidelines related to diagnoses
    - Compare utilization of services to standards of care that are age/gender specific
    - Review access to services for trends (ER utilization, PCP visits, hospitalizations, pharmacy use)
    - Review authorizations and other claims submissions to gather information on all rendering providers.
- Compare MCO portal information to the member information contained in the HHP health record and update as appropriate
- Outreach to the member (Phone calls, letters, emails, and face to face visits)
- Once contact is made with the member- verify the utilization information that has been gathered, establish rapport
- Request records from associated providers as needed
- Schedule/complete the comprehensive assessment
- Work with member to determine health goals based upon gaps in care or other needs identified during the assessment and/or subsequent meetings
- Develop the HAP and submit to the MCO (if applicable)

Comprehensive Transitional Care

Goal: For each HH member transferred from one caregiver or site of care to another, the HHP coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. The following activities are examples of the services that may be included in providing Comprehensive Transitional Care and should be documented thoroughly in the member's care record.

Scenario: The HHP is notified or becomes aware of an inpatient admission, ER visit, or other transitional care event.

- Call the member or the facility to obtain details of the admission/event
- Request discharge summary from the facility and confirm PCP/specialists have received a copy as appropriate
- Work with discharge planner at facility to schedule follow up visits (within 72 hours of discharge for behavioral health follow up appointments and within 7 days of discharge for physical health follow up appointments)
- Ensure transportation is arranged if needed
- Offer to attend follow up appointments if member needs assistance
- Reconcile medications, provide medication education, and notify all rendering providers of reconciled medication list
- Update HAP if needed (submit to the MCO if applicable)
- Determine need to update comprehensive assessment (if condition indicates substantial change in health)
- Determine if update in needs assessment related to waiver service, LTSS supports/services (if applicable), change in Person Centered Support Plan (if applicable), home modifications, durable medical equipment needs, home health needs, therapy needs/appointments, home safety modifications, offer assistance to family/other supports, provide referrals to community service providers if indicated
- Confirm member understanding of follow up and/or self- care related to inpatient stay or ER visit
- Follow member progress at least once weekly after discharge to ensure attendance at follow up appointments, medication adherence, self- care, etc. Weekly follow up should occur for 30 days post discharge.

Health Promotion

Goal: Health promotion involves assessing members understanding of their health conditions, health literacy, and motivation to engage in self-management. Health Promotion includes linking members to educational resources that focus on smoking cessation, diabetes, asthma, hypertension, recovery, and/or other health conditions. HHPs will assist members as they learn to manage their own health and mitigate complications related to their conditions in the prevention the development of other chronic conditions. The following activities are examples of the services that may be included in providing Health Promotion and should be documented thoroughly in the member's care record.

Scenario: The Care Coordinator reviews health information for a member and identifies a possible gap in diabetes care. The Care Coordinator has received care records for the member from the PCP and confirmed the diagnosis of diabetes but the member denies this diagnosis. The Care Coordinator meets with the member to discuss the diagnosis, shares the health information received from the PCP (or other provider) that confirms the diagnosis, and explains the meaning of the information. The Care Coordinator helps the member understand next steps in maintaining good health, how to utilize their benefits to manage their health care, and offers other resources that may provide additional support for diabetes management.

- Encouragement and support of healthy ideas and behaviors
- Engages members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment
- Provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions
- Helps to identify and share opportunities to participate in health education classes, seminars or health fairs
- Utilizes MCO data or other data to identify opportunities to engage the member in self- care, verifies member understanding of self-care and provides self-care education as needed
- Encourages member to complete wellness checks as appropriate for their conditions
- Discusses the importance of self- advocacy and coaches member on how to be their own self advocate

Referral to Community and Social Supports

Goal: Referral to community supports and services includes long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. The following activities are examples of the services that may be included in providing Referral to Community and Social Supports and should be documented thoroughly in the member's care record.

Scenario: The Care Coordinator arrives at the member's home for a scheduled visit. The member appears disheveled and is having difficulty walking. During the visit the Care Coordinator asks the member if they are having difficulty in walking. The member states that it has become difficult to walk without having the support of holding onto items throughout the home and self-care has become more difficult as well. The member states there are no family members in the area to assist and they don't have the income to pay for a helper. The Care Coordinator compiles a list of the members needs and begins the process of identifying, explaining and managing referrals to resources that may be available to assist the member.

- Completing or following up on referrals to community supports and services as needed
- Assisting the member in advocating for access to care by helping to complete paper work and/or applications, making phone calls
- Identifying and establishing natural supports if services providers are unavailable in the member's community
- Assist member in establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, food pantries, meals on wheels, home health, utility assistance
- Provides comprehensive explanation of all options for managing needs so member can make informed choices